Outcomes Framework for Older People and Adult Community Services to improve health, wellbeing and maintain independence.

Outcomes and indicators

Mark 2 version

March 2014
Commissioning for Outcomes

The NHS has historically focused on measuring service ‘inputs’ (such as attendances and admissions to hospital) and processes (such as waiting times). These have some value, but do not tell us whether the patient’s experience of health care was good or bad, nor whether it was clinically effective. The NHS is developing approaches which address these shortcomings by measuring patient outcomes.

Cambridgeshire and Peterborough CCG believe that commissioning for outcomes is the right approach for care of older people in particular, many of whom will need a wide range of services delivered in a coordinated way. We have developed our local ‘framework’ for measuring outcomes in a way which places emphasis on the patient experience and clinical outcomes, but still takes account of the process of service delivery.

The CCG Outcomes Framework is based on seven domains, which will form the basis for the service specification to drive improvement in quality and outcomes:

- Ensuring people have an excellent and equitable experience of care and support, with care organised around the patient
- Treating and caring for people in a safe environment and protecting them from avoidable harm
- Developing an organisational culture of joined-up working, patient-centred care, empowered staff and effective information sharing
- Early intervention to promote health, well-being and independence
- Treatment and / or support during an acute episode of ill health
- Long term recovery and sustainability of health
- Care and support for people at the end of their lives

Current NHS funding and contract mechanisms are not to any great extent linked to outcomes for patients. The CCG’s approach aims to address this by linking a proportion of funding to achievement of specific outcome measures (‘Payment By Outcomes’ or PBO). This will be in addition to the requirements under the standard NHS contract.

The Outcomes Framework structure Mark 2 version is as follows:

- Seven high level domains – see figure 2 on page 5.
- Each domain has several outcomes – see the summary in figure 3 on page 6.
- Each outcome has one or more indicators which should reflect if the outcome has been achieved – pages 26-37.

The outcome measures are a mix of outcomes and proxy process measures. There will be a defined process for review and revision of a proportion of the Outcomes Framework indicators each year.
1 Introduction

Providers will be expected to deliver integrated pathway services for older people and adult community services in line with core contract standards including national and local quality standards and NHS Constitution principles. In addition, an outcomes-based commissioning approach will be employed to shift the emphasis from what services will be provided to also consider what outcomes will be achieved.

A percentage of the Contract Value will be paid on achievement of Outcome Framework indicators. Setting specific objectives by which to measure and manage performance is a key step in achieving effective transformation of joined-up, patient centred care for older people. Linking these objectives to contract measures and financial incentives will ensure high quality care, organisational performance and achievement of programme goals. A draft Outcomes Framework has been produced which sets out the specified outcomes, and draft indicators, derived from national outcome frameworks and evidence-based quality standards, local data sources, national guidance and research on patient experience, the expert perspective of clinical leads and patient views from our local population.
2 Method of identifying relevant outcomes and developing performance indicators

2.1 Identification of target populations

Three target populations were identified which can be best conceptualised adapting the Kaiser Triangle model of differing levels of chronic care\(^\text{19}\) (see Figure 1).

Acute and community care will be focused on:

1. The proactive identification of frail older people (aged 65 and over) who are particularly vulnerable to avoidable hospital admissions. A case management approach to supporting these individuals will include early interventions to improve their physical and mental health, wellbeing and maintain their independence.

2. The provider will also be responsible for community care services for adults and older people with long term conditions who fulfil the criteria for referral to services.

3. There is an incentive for providers to focus on upstream preventative interventions for the entire population of those aged 65 and over to improve health and wellbeing and maintain independence for as long as possible. This will include partnership working with voluntary organisations to provide advice, signposting to local information and community support where needed.

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2.2 Mapping of outcomes along the clinical pathway

A mapping exercise was performed by the CCG Outcomes workstream, working with clinical leads to consider desired outcomes for the service across the clinical pathway. Figure 2 illustrates how outcomes were considered along a patient pathway of three key stages for all patients (modified from Porter’s Hierarchy of outcomes),19 with an additional pathway domain (4) for patients who require end of life care. Core outcomes are also described for three overarching domains which cross the entire patient pathway (A - patient experience, B – patient safety & C - organisational culture). Figure 3 summarises the outcomes for each domain.

Figure 2: Programme Outcome Domains – throughout a patient pathway for physical and mental health and wellbeing

Figure 3: Draft Outcomes Framework for Older People and Adult Community Services to improve health, wellbeing and maintain independence.

**Overarching domain A: Ensure people have an excellent and equitable experience of care and support with care organised around the patient and their carers/family**

A.1 Patients and their carers, have an overall excellent experience of care and support.
A.2 Patients and carers experience effective joined-up working and co-ordinated care.
A.3 Patients and carers are aware of, and involved in, the planning of their care.
A.4 Patients and their carers have access to information in an appropriate way, when they need it.
A.5 Patients and their carers feel supported to manage at home and maintain their independence and wellbeing.
A.6 Patients and their carers feel supported in the community following discharge and during their recovery period.

**Overarching domain B: Treat and care for people in a safe environment and protect them from avoidable harm**

B.1 There is a reduction in premature mortality from major causes of death.
B.2 There is a reduction in the number of adverse experiences for patients and carers.
B.3 Robust systems and measures in place for infection control including high impact interventions.
B.4 Robust measures are in place to ensure learning from audits and reviews of patient care.
B.5 Care is provided in a safe environment with robust safeguarding plans and processes in place.

**Overarching domain C: Develop an organisational culture of joined-up working, patient centred care, empowering staff and effective information sharing**

C.1 Staff, and whole organisations, are committed to working in a joined up and integrated way and integrated working is evident across and within organisational boundaries.
C.2 There is evidence of progress towards transformational change of workforce and work practices.
C.3 Effective information sharing and IT systems are in place and valued by staff across all local provider organisations.
C.4 There is an organisational culture that supports staff to learn, improve and feel empowered.

**Pathway domain 1: Support older people and people with long term conditions (LTCs) through early interventions and evidence-based care to improve their health, wellbeing and maintain their independence**

1.1 Individuals with long term conditions experience improved control and reduced complications.
1.2 All individuals with a long term condition (under the care of community services), and their carers, feel supported to manage their condition and maintain their independence.
1.3 The health and independence of frail older people is maintained or improved through proactive identification, assessment and care planning.
1.4 There is a reduction in the number of older people who suffer injury and/or fractures from a fall.
1.5 Individuals experience improved mental health and wellbeing and quality of life through early support and diagnosis.
1.6 Evidence-based advice and interventions are made available to all people in contact with community services to promote healthy lifestyles and behaviours.

**Pathway domain 2: Support older people and those with a LTC with an acute deterioration or inability to cope at home, to prevent avoidable admissions and reduce unnecessary hospital stays**

2.1 There is a reduction in the number of days spent in hospital (from emergency admissions) by those aged 65 and over.
2.2 The impact of the programme on planned care is assessed and not adversely impacted.
2.3 The community team effectively manages acute health episodes, minimising unnecessary hospital admissions where medically appropriate.
2.4 When referred to hospital or presenting to A&E frail older people are pro-actively managed along an integrated frailty pathway.
2.5 Patients aged 65 and over and those with LTCs experience a timely and supported discharge from acute or community settings.

**Pathway domain 3: Promote recovery, rehabilitation and sustainability of health and functional status after a period of ill health or injury, with supported discharge and reduced readmissions**

3.1 Patients make a sustainable recovery after admission to acute or intermediate care, with no avoidable deterioration in health.
3.2 Patients feel supported in the community following discharge and during their recovery period.

**Pathway domain 4: Optimise the experience of care of people approaching the end of their lives (and their carers) in all settings and at all times of the day and night**

4.1 The quality of care experienced by the person who died, and their families, as reported by carers, was excellent.
4.2 Community staff are trained and enabled to look after those who are dying in an appropriate and compassionate way.
4.3 Those who are dying can access high quality care which is co-ordinated across different agencies and staff.
2.3 Identifying indicators to measure outcomes and quality improvement

Five domains of measurement were identified from which to derive information to understand and monitor improvement in health, wellbeing, independence and quality of integrated services for these populations at each stage in the pathway.\(^{19}\)

- patient and carer experience
- clinical outcomes, including patient safety
- service utilisation process measures e.g. emergency bed rates, readmissions
- organisational culture and staff experience
- sustainability of costs.

A scoping review was performed to describe current national benchmarked outcomes or indicators in the NHS,\(^{20}\) Public Health,\(^{21}\) Social Care\(^{22}\) and CCG\(^{23}\) National Outcomes frameworks, national data sets for specific populations (e.g. the Older Peoples Health and Wellbeing Atlas \(^{24}\)) or specific diseases (e.g. Stroke Sentinel Audit,\(^{25}\) National Intermediate Care Audit,\(^{26}\) End of Life Care Audit,\(^{27}\) National Bone Audit \(^{28}\)) and local Commissioning Health data sets including Secondary Uses Service data (CDS (SUS)). Key aspects of measuring patient experience were reviewed including national reports (e.g. the National Voices survey \(^{29}\)) and patient reported outcome measurement tools were described (Euro-Qual 5Q and SF-36).

Indicators were identified for each desired outcome of the programme. Indicators are ‘succinct measures that aim to describe as much about a system as possible in as few points as possible… which help us understand a system, compare it and improve it.’\(^{30}\) The two most essential features of an indicator are that it has to be important and relevant to the objectives of the system or organisation it is measuring and to be intrinsically valid (measure what it claims to measure). A description of the rationale for choosing each indicator is described in the technical specifications, which outlines the evidence base supporting the measurement of this indicator, and an assessment of the feasibility of using this indicator to monitor the desired outcome. Further work has been conducted during the dialogue phases of Invitation to Submit Online Solution (ISOS) to review and assess chosen indicators against specific criteria, such as validity and relevance, for the final Outcomes Framework.

Any indicator will give only a very specific and limited perspective, each measuring an important but different aspect of the system. As such, where possible and feasible, indicators have been identified to triangulate information on each outcome using patient and carer experience, staff or provider experience, service process measures and clinical outcomes.

2.4 Summary of sources of information

A variety of sources of information were identified to use information as indicators. These included:

- **National Outcome Frameworks for NHS, Public Health, CCG and Social Care**: Some system-
wide indicators for older people have been identified in the National Outcomes Frameworks which are published nationally e.g. falls related data, functional status 90 days after stroke (see Appendix 1). There are also a number of relevant national outcomes which are reported for all ages or for the entire health and social care economy where we might wish to know the data for this specific population. In these cases, providers will be asked to submit local data for those aged 65 and over. This will enable local analysis of validated outcomes for this specific population.
• **NICE Quality standards & national audits:** It is expected that all services will be evidence-based and meet NICE Quality standards. For some specific diseases and pathways, progress can be measured against outcomes monitored in national audits e.g. Stroke Sentinel Audit, End of Life Care Audit, National Bone Audit or mapped against quality standards where available. It is important to note that available evidence or quality standards does not necessarily reflect local need, so it is important not to over-emphasise specific available standards for certain diseases, to the detriment of other clinical conditions where the evidence is more limited.

• **NHS Constitution requirements and NHS Standard Contract requirements:** These will continue to be monitored through monthly performance reports.

• **Quality reporting measures:** As part of the contract, providers will be expected to provide quality assurance data to meet national and local quality requirements for the Older People Quality Dashboard. These will include for example: describing their compliance with CQC standards, clinical audits, patient safety processes, escalation of quality issues and action in response to serious incidents. Measures will also be monitored and discussed with primary care, to monitor any adverse patient or service related outcomes e.g. age stratified mortality rates; use of planned care services; Quality and Outcomes Framework (QoF) disease specific measures relating to long term conditions (LTCs).

• **Patient and care reported measures:** Providers will be expected to include measures of patient and carer satisfaction and experience as part of the care pathway, and to provide evidence of actions resulting from patient feedback.

• **Independent evaluation of patient and carer experience:** Providers will be expected to commission an independent patient survey for patients in contact with these services. The format, content and frequency of the survey is open to dialogue and discussion with providers, e.g. face to face interviews versus telephone or written questionnaires, timing of questionnaires, inclusion of carers views, etc. The provider will be expected to commission an independent patient and carer experience survey which will include a section relating to overall experience of care for all patients, plus specific additional sections to investigate aspects of care for specific groups of patients and carers e.g. frail older people who receive a multi disciplinary team (MDT) package, those who receive a rapid response or require admission to acute care. The results of this survey will be reported monthly to the commissioner. More detail about this is described in domain A.

• **Measurement of clinical outcome:** Providers will be expected to record and report clinical outcomes in personal care records, and to incorporate a measure of patient self-reported health and functional outcome as part of the care pathway. This is intended to provide a measure of quality and effectiveness, which can be used meaningfully in an ‘internal feedback’ loop in real-time to inform and enhance the patient experience and quality of care.

• **Feedback from primary care and other stakeholders:** Providers will be expected to work collaboratively with primary care to develop shared pathways of care, effective sharing of information and joint decision-making and care planning. Providers will be expected to develop a mechanism for receiving feedback from GPs and provide a timely response to concerns regarding patient care or delayed action (e.g. GP online questionnaire or feedback submission). Providers will also be expected to develop mechanisms for receiving and responding to ‘360 feedback’ from all partners and stakeholders such as social care, primary care, housing, voluntary and independent sector.

• **Staff surveys:** Providers will be expected to conduct staff surveys to gain feedback on integrated care and joint-working on the ground, in addition to the NHS staff survey. More detail about this is described in domain C.

31  Stroke Sentinel Audit. Available at: http://www.rcplondon.ac.uk/resources/national-sentinel-stroke-audit
33  National Bone Audit. Available at: http://www.rcplondon.ac.uk/projects/national-audit-falls-and-bone-health-older-people
• **Annual report**: The provider will be asked to present an annual/bi-annual report to the commissioner describing their overall strategy for transforming care and improving quality, any additional measures they are monitoring, an assessment of local needs and their prevention strategy to support the local population of older people to be independent, safe and well. This aims to encourage and monitor the preventative approach, and to contribute to the JSNA and local knowledge to inform local commissioning.

### 2.5 Dialogue and development with providers

The original draft framework described key outcomes and proposed indicators identified for dialogue with potential bidders. During the ISOS dialogue process bidders were asked to review and comment on the framework to enable the CCG to gauge their perspectives on:

- the validity and relevance of the indicators across the seven domains of the Outcomes Framework (see figure 2)
- the practicalities and resources associated with the collection of data for the proposed indicators.

The original framework proposed a mixed economy of indicators:

- **non-negotiable**: For these indicators, providers would be required to report the information as stated e.g. NHS Constitution measures, Older People Quality Dashboard, local data on selected specific measures which were agreed as mandatory (e.g. NHS OF measures, emergency bed day rates). There may be dialogue with providers to agree trajectories to meet specified targets.

- **for dialogue**: These indicators describe core information to be monitored but were open to some negotiation and dialogue with providers about whether there may be better methods of measuring them, where new baselines need to be constructed/understood in the first year or setting aspirational but achievable targets and trajectories e.g. specific measures for patient groups/LTC e.g. COPD, diabetes, mental health; Patient experience measures embedded in care pathways and in the patient surveys.

- **developmental**: These were indicators which require more innovative thinking about how we measure this outcome. We proposed to work closely with providers to develop new ways of measuring these outcomes either where no measurement currently exists or there are various bespoke models which could be supported or developed e.g. patient reported outcome measures using Euroqol 5D or SF36 or similar; dashboards to monitor organisational culture and transformational change.

### 2.6 Testing with stakeholders

Further discussions were held with patient representatives, the voluntary sector, social care colleagues and GPs to identify local desired outcomes for this programme and what indicators or information might be used to measure quality and improvement.

Following dialogue the Outcomes Framework has been through some additional testing/review with patients as well as key clinical and managerial subject matter experts (SMEs) including reviews conducted by Dr Veena Raleigh, Senior Fellow in Epidemiology with the King’s Fund and by COBIC (a national specialist organisation which advises the NHS on outcome based commissioning). Additional national integrated care indicators recommended by the Picker Institute in January 2014, 34 were also reviewed for inclusion.

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Following this comprehensive review, all associated feedback was collated and each indicator assessed for inclusion in the Mark 2 framework. Indicators were judged on inclusion criteria which included: evidence of relevance and strategic importance to the pathway, validity, feasibility and logistics of data collection. The aim was to create a final basket of indicators which are feasible to implement, manageable in number, and as ‘simple as possible but complex as necessary’ to assess a complex system of care (as per ‘guiding principles’ described in the ISOS and ISFS prospectus). They have all been tested as relevant to local stakeholders and aim to triangulate information on patient and carer experience, clinical outcomes and service processes. Some indicators are innovative and will require significant development. All aim to directly enhance the experience of patients and their carers and to improve the pathway of care.

Further testing of this revised framework with bidders and other stakeholders was conducted to check the feasibility of each indicator and assess the framework against potential clinical scenarios to assess for unintended consequences.

3 Understanding and using this document

Section 4 of this document describes the proposed indicators under each outcome and details supporting evidence. Technical specifications are available for each indicator.
4 Draft Outcomes Framework

Overarching domain A: Ensure people have an excellent experience and equitable experience of care and support, with care organised around the patient

Rationale:

- a successful patient-centred service means that key outcomes should be focussed on understanding and improving patient experience. By asking, monitoring, and acting upon patient feedback, organisations are able to make improvements in the areas that patients say matter most to them. Providers will be expected to illustrate how they have involved patient and local communities in developing solutions and services, in their organisational structure, as well as involving patients and carers in their own individual care

- this is a key element of NHS Outcomes Framework Domain 4: ‘Ensuring that people have a positive experience of care’. Respect and Dignity, Commitment to Quality of Care and Ensuring Everyone Counts are key values to NHS patients, public and staff and should underpin all elements of care

- patients, and where appropriate their family and carers, have a legal right to be involved in discussions and decisions about their health and care, including end of life care, and to be given information to enable them to do this. As well as enabling partnership planning this will also support the NHS Constitution pledge to use patient experience feedback to improve services. The Department of Health (DoH) (2006) suggests that informed patients also have better health outcomes; the more they understand about their conditions, the more empowered they are and the more likely they are to be concordant with treatment. Access to paper and electronic medical records is also important: patients report feeling better informed and having a sense of control over their own health and health care. Access to records can also help break down barriers between patients and doctors, thereby improving consultations and their relationships with health professionals

- there is a national commitment to improving the experience of patient and carers of ‘integrated care’ – defined by National Voices from the perspective of an individual as “I can plan my care with people who work together to understand me and my carer(s), allowing me control, and bringing together services to achieve the outcomes important to me.” In August 2012, the DoH produced a summary of interim integration measures of patient experience, derived from the seven core questions that are routinely collected in existing national patient surveys. The National Voices Survey (2012) also proposes that patient experience surveys of integrated care can be developed using neutral, objective questions to enable patients to report what was good or bad about their care. These statements have been used to define broad patient and carer outcomes in this domain which apply across the whole pathway. Specific patient experience relevant to each stage is also listed throughout other domains.

Sources:

- the provider will be expected to commission an independent patient and carer experience survey which will include a section relating to overall experience of care for all patients, plus specific additional sections to investigate aspects of care for specific groups of patients and carers e.g. frail older people who receive an MDT package, those who receive a rapid response or require admission to acute care. The results of this survey will be reported monthly to the commissioner.

- patient experience surveys are specifically designed to capture the directly-reported experience of patients and service users, as opposed to capturing qualitative measures of satisfaction or perception. This local questionnaire should include a combination of: validated questions from the National Patient Survey programme run by the Care Quality Commission; adapted statements derived from patients about what they value most from the National Voices Integrated Care study; and additional questions developed by the provider.

- all the surveys used should be based on simple random sampling and conducted using high professional statistical and research standards. This includes careful processes for issuing reminders and checking response rates from different demographic groups in order to avoid any response bias in the results.

- the commissioner is open to dialogue about the development of the survey and additional measures which might be developed for useful feedback for the provider. The minimum information required is set out in the indicators below. It is expected that providers will triangulate this information through collecting and extracting measures of patient involvement in care plans and goal setting which are recorded in patient notes at appropriate stages along the care pathway.

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## Overarching Domain A: Ensure people have an excellent and equitable experience of care and support, with care organised around the patient and their carers/family

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<tr>
<th>Outcomes (overarching measures)</th>
<th>Indicators</th>
<th>Linked ‘I’ statements</th>
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<tbody>
<tr>
<td><strong>A.1 Patients and their carers, have an overall excellent experience of care and support</strong></td>
<td>A.1.1 The number of positive recommendations to friends and family from people receiving treatment or care, referring to a) A&amp;E experience, b) inpatient episodes and c) community services.</td>
<td>This is a global measure which takes into account overall satisfaction</td>
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<td>A.1.2 Proportion of patients and their carers who are in contact with services and report that they are treated with respect and dignity by all staff involved in their care.</td>
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<td>A.1.3 Proportion of patients and carers who report that carers/family had their needs considered and were given support.</td>
<td>‘My family and carer had their needs looked at and were given support to care for me.’</td>
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<td>A.1.4 Review of patient feedback using ‘Patient Opinion’ or other real-time feedback systems, to include details of positive and negative feedback and action on identified areas of concern</td>
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<td>A.1.5 Action following Patient-Led Assessments of the Care Environment (PLACE)</td>
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<td>A.1.6 Participation in all relevant national patient experience surveys, with action plans for improvement</td>
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<td><strong>A.2. Patients and carers experience effective joined-up working and co-ordinated care</strong></td>
<td>A.2.1 Proportion of patients and carers who report that they felt those involved with their care worked as a team (including communicating well together, sharing information and co-ordinating care).</td>
<td>‘The professionals involved with me talked to each other. I could see that they worked as a team’</td>
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<td>A.2.2</td>
<td>Proportion of patients and carers who report that they know who the first point of contact or lead professional was for all aspects of their care.</td>
<td>‘I always knew who was the main person in charge of my care who helped me to get other services and help, and to put everything together.’ ‘When something was planned and agreed to, it happened without me having to chase around for it’</td>
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<td>A.2.3</td>
<td>Proportion of patients and carers who report that their history and care plan was known and used by all involved in their care.</td>
<td>‘Information about me, including my views and preferences and any agreed care plan was passed on in advance’</td>
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<td>A.3 Patients and carers are aware of, and involved in, the planning of their care</td>
<td>A.3.1 Proportion of patients who have been asked whether they consent to sharing their information, for whom a response has been recorded.</td>
<td>‘When I went to a new care setting or met a new team, they knew who I was, what my circumstances were, and about my own views and preferences, and any care plans I had made.’</td>
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<td>A.3.2</td>
<td>Proportion of patients and carers who agree that: • they have been involved in the planning of their care and are aware of the treatment options available; • they understand all the elements of their care, including the medicines they have been prescribed; • their choices and preferences are reflected in their care plan.</td>
<td>‘I was as involved in discussions and decisions about my care and treatment as I wanted to be.’ ‘My family or carer was also involved in these decisions as much as I wanted them to be’ ‘I was always kept informed about what the next steps would be’ ‘I had regular reviews of my care and treatment and of my care plan’</td>
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<td>A.3.3</td>
<td>Proportion of patients and carers who report that they have access to their own care plans and records.</td>
<td>‘I could see my health and care records at any time to check what was going on. I could decide who to share them with, I could correct any mistakes in the information’</td>
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<td>A.3.4</td>
<td>Proportion of patients with dementia and/or a learning disability, and their carers, who report that reasonable adjustments were made for them.</td>
<td>‘I was as involved in discussions and decisions about my care and treatment as I wanted to be.’ ‘My family or carer was also involved in these decisions as much as I wanted them to be’</td>
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<td></td>
<td>A.3.5</td>
<td>Proportion of individuals with dementia and/or learning disabilities or autism known to services who have a care plan/hospital passport which includes an assessment of communication needs and reasonable adjustments.</td>
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<td>A.4 Patients and their carers have access to information in an appropriate way, when they need it</td>
<td>A.4.1 Proportion of patients and carers who report feeling supported with appropriate access to information when required.</td>
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<td>‘Information was given to me at the right times. The information was appropriate to my condition and circumstances’</td>
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<td>‘The information I was given was comprehensive: it was not just medical, but helped me understand the impact of my health status on other parts of my life’</td>
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<td>A.4.2</td>
<td>Proportion of patients who report that they feel informed and involved in decisions about their medicines.</td>
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<td>‘If I needed a new medicine, its purpose, potential side effects and how to take it were explained to me. I was given written information about this.’</td>
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<td>‘I was as involved as I wanted to be in decisions about my medicines – whether they were needed and which one to choose.’</td>
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<td>‘I had regular comprehensive reviews of my medicines’</td>
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<td>A.4.3</td>
<td>Proportion of patients and their carers who report that they are informed and have access to advice about healthy behaviours such as a nutritious diet, physical activity, smoking cessation and support for mental health and wellbeing.</td>
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| A.5 Patients and their carers feel supported to manage their at home and maintain their independence and wellbeing | A.5.1 Proportion of people feeling supported to manage their condition. | ‘Taken together, my care and support help me live the life I want to the best of my ability’
‘I felt supported to manage at home and I knew who to contact for advice about my condition or who to go to when in crisis’
‘When I need support to live at home, services worked together to provide it. I had a say in who would come and provide my care and when, when I need special equipment to live at home, it arrived in good time.’ |
| A.5.2 Proportion of patients and their carers who report they were told about other services that were available to someone in their circumstances, including voluntary sector services, District Council services (including housing support) and local community support or activities. | ‘I was told about other services available to someone in my circumstances, including local and national support organisations’ |
| A.5.3 Proportion of frail individuals who have a health and social care summary and plan, and their carers, who report that they know what to do and who to contact in an emergency, and were satisfied with the speed of response they received. | ‘When my professional knew there was a risk of emergencies happening, they:
Put measures in place to prevent that;
Ensured I was regularly contacted to check on me;
Gave me ways to sound an immediate alert if I was at risk.’
‘When I went to a new (care setting or met a new team/place): they knew who I was, what my circumstances were, about my own views and preferences and any care plans I had made’ |
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<td><strong>A.6 Patients and their carers feel supported in the community following discharge and during their recovery period</strong></td>
<td>A.6.1 Patients and carers report that: they were not in hospital or a care setting for longer than medical necessary their care was arranged and co-ordinated without unnecessary delays.</td>
<td>‘When I was discharged from a service, there was a plan in place for what happened next. This was delivered without unnecessary delays’</td>
</tr>
<tr>
<td></td>
<td>A.6.2 Proportion of patients and carers who report that when they were discharged from a service, a plan was in place for what happened next and it was delivered without unnecessary delays.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A.6.3 Proportion of patients and carers who report that they knew who to contact if worried about their condition or treatment after leaving hospital or finishing a series of treatment.</td>
<td>‘I felt supported to manage at home and I knew who to contact for advice about my condition or who to go to when in crisis’</td>
</tr>
</tbody>
</table>
Overarching domain B: Treat and care for people in a safe environment and protect them from avoidable harm

Rationale:

- linked to NHS Outcomes Framework Domain 5: ‘Treating and caring for people in a safe environment and protecting them from avoidable harm’

- this domain links closely to Older People Quality and Safety Dashboard, so providers can be benchmarked against providers of other commissioned services

- Lord Darzi’s report ‘High quality care for all’ highlighted the importance of the entire patient experience within the NHS, ensuring people are treated with compassion, dignity and respect within a clean, safe and well-managed environment

- the NHS Safety Thermometer has been designed to be used by frontline healthcare professionals to measure a snapshot of harm once a month for core clinical adverse outcomes:
  - pressure ulcers
  - falls in care settings
  - urinary infection in patients with catheters; and
  - venous thromboembolism.

It is called the NHS Safety Thermometer because it takes only a minimum set of data to help signal where individuals, teams and organisations might need to focus more detailed measurement, training and improvement.

- “There is a strong correlation between age and adverse patient safety incidents. This reflects increasing frailty with age. The transfer of patients from secondary care to home/long term care is an area that can lead to patient safety incidents, especially in the absence of a comprehensive geriatric assessment on admission. The majority of errors seem to be related to medication or adverse drug events, diagnostic test errors, nosocomial infections and falls whilst waiting for transfer.”

- “There is weak evidence in the literature to relate number of co-morbidities to adverse patient safety incidents, and is linked with the age/frailty driver. Adverse safety incidents come in the form of falls, transfer to long term care, poor communication, poly-pharmacy and so on.”

- “Good infection prevention and control are essential to ensure that people who use health and social care services receive safe and effective care. Effective prevention and control of infection must be part of everyday practice and be applied consistently by everyone. Good management and organisational processes are crucial to make sure that high standards of infection prevention and control are achieved.”


control are developed and maintained.”\textsuperscript{36}

- the Manchester Patient Safety Framework is designed to identify the sequence of events, working back from the incident, using a retrospective and multidisciplinary approach.\textsuperscript{37} It has three parameters:
  - Patient Safety Incident (PSI): Any unintended or unexpected incident that could have or did lead to harm to one or more patients receiving NHS-funded healthcare.
  - Prevented Patient Safety Incident (PPSI): Any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to patients receiving NHS-funded healthcare.
  - Root Cause Analysis (RCA): A technique for undertaking a systematic investigation that looks beyond the individuals concerned and seeks to understand the underlying causes and environmental context in which the incident happened.

- The framework defines 10 dimensions of a patient safety culture:
  - commitment to overall continuous improvement
  - priority given to safety
  - system errors and individual responsibility
  - recording incidents and best practice
  - evaluating incidents and best practice
  - learning and effecting change
  - communication about safety issues
  - personnel management and safety issues
  - staff education and training
  - team working.

**Sources:**

- local mortality rates including specific mortality rates for certain conditions as recommended by NICE.
- reporting measures from providers for the Older People Quality Dashboard, including the National Patient Safety Thermometer; Patient safety incident reporting
- health protection surveillance measures of infectious disease prevalence for c.difficile and MRSA (Public Health England)
- patient and carer experience surveys and patient complaints
- quality assurance from the provider including processes, audits and evidence of training and culture of shared learning for patient safety, infection control and safeguarding practices.


\textsuperscript{37} Manchester Patient Safety Framework tool. Available at: http://www.nrls.npsa.nhs.uk/resources/?entryid45=59796
## Overarching Domain B: Treat and care for people in a safe environment and protect them from avoidable harm

<table>
<thead>
<tr>
<th>Outcomes (overarching measures)</th>
<th>Indicators</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>B.1 Reduction in premature mortality from major causes of death</strong></td>
<td>B.1.1 Age-specific mortality rates (stratified by sex) and investigation of services where mortality rates are outliers, with action plans where required</td>
<td>CCG Quality Dashboard Metric 15</td>
</tr>
<tr>
<td><strong>B.2 Reduction in the number of adverse experiences for patients and carers</strong></td>
<td>B.2.1 Provider patient safety and quality dashboard publicly available, with information by clinical setting, department or service</td>
<td>CCG Quality Dashboard Metric 3</td>
</tr>
<tr>
<td></td>
<td>B.2.2 Evaluation of the patient safety culture of the organisation using a cultural barometer tool (or equivalent)</td>
<td>CCG Quality Dashboard Metric 2 &amp; 8a</td>
</tr>
<tr>
<td></td>
<td>B.2.3 Report on patient complaints and management and learning associated with them</td>
<td>CCG Quality Dashboard Metric 4</td>
</tr>
<tr>
<td></td>
<td>B.2.4 NHS Safety thermometer: Percentage of patients with harm free care: pressure ulcers, falls in care settings, venous thromboembolism; urinary infections in individuals with catheters (including reports on action being taken to reduce harm)</td>
<td>CCG Quality Dashboard Metric 10a, 10b, 11b, 11c</td>
</tr>
<tr>
<td></td>
<td>B.2.5 Incidence of medication errors causing serious harm.</td>
<td></td>
</tr>
<tr>
<td><strong>B.3 Robust systems and measures are in place for infection control including high impact interventions</strong></td>
<td>B.3.1 Infection control quarterly report including assurance of systems and measures for Infection Prevention and Control</td>
<td>CCG Quality Dashboard Metric 16</td>
</tr>
<tr>
<td></td>
<td>B.3.2 Zero tolerance for avoidable MRSA bacteraemia infections</td>
<td>CCG Quality Dashboard Domain 16</td>
</tr>
<tr>
<td></td>
<td>B.3.3 Number of c.difficile infections per quarter</td>
<td>CCG Quality Dashboard Domain 16</td>
</tr>
<tr>
<td><strong>B.4 Robust measures in place to ensure learning from audits and reviews of patient care</strong></td>
<td>B.4.1 Clinical audit programme &amp; plan which evidences learning from national and local audits, and informed by serious incidents, incidents and complaints.</td>
<td>CCG Quality Dashboard Metric 19</td>
</tr>
<tr>
<td>Outcomes (overarching measures)</td>
<td>Indicators</td>
<td>Source</td>
</tr>
<tr>
<td>---------------------------------</td>
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</tr>
<tr>
<td>B.4.2 Timeliness and standard of SI reporting</td>
<td>CCG Quality Dashboard Metric 20a &amp; 20b</td>
<td></td>
</tr>
<tr>
<td>B.4.3 Number of SIs reported each month and number of open SIs and Never Events (including fit for purpose action plan for Never Events where relevant)</td>
<td>CCG Quality Dashboard Metric 20c &amp; 20d</td>
<td></td>
</tr>
<tr>
<td>B.5 Care is provided in a safe environment with robust safeguarding plans in place including staff training across the provider-led system plus audit for protecting vulnerable adults from avoidable harm with responsive action plan.</td>
<td>B.5.1 Development and implementation of good practice in safeguarding children, including demonstration of good practice (evidenced through audit, SAAF reports and annual report)</td>
<td>CCG Quality Dashboard Metric 17a, 17b, 18a &amp; 18b</td>
</tr>
<tr>
<td>B.5.2 Proportion of relevant staff trained in safeguarding adults and children</td>
<td>CCG Quality Dashboard Metric 17c &amp; 18c</td>
<td></td>
</tr>
<tr>
<td>B.5.3 Percentage of relevant staff trained in Mental Capacity Act and Deprivation of Liberty</td>
<td>CCG Quality Dashboard Metric 18</td>
<td></td>
</tr>
<tr>
<td>B.5.4 Numbers of staff who have received PREVENT training.</td>
<td>CCG Quality Dashboard Metric 18</td>
<td></td>
</tr>
</tbody>
</table>

Additional quality dashboard reporting contract requirements for review by CCG, including:

- Progress towards compliance with NICE Quality Standards (CCG Quality Dashboard Metric 21);
- Implementation of Patient Safety (CAS) alerts (CCG Quality Dashboard Metric 22);
- Cost Improvement programme (CCG Quality Dashboard Metric 23);
- Draft Quality Account (CCG Quality Dashboard Metric 24);
- Information Governance Annual Report and action plan (CCG Quality Dashboard Metric 13).
Overarching domain C: Develop an organisational culture of joined-up working, patient centred care, empowered staff and effective information sharing

Rationale:

- linked to NHS Business Plan 2013/14 – 2015/16 ‘Putting patient first’ Priority 10: Becoming an excellent organisation
- there is a clear dialogue from integrated care pilot studies and international examples about the importance of a clear vision, a shared narrative\(^ {38}\) and collaborative leadership with good governance arrangements around decision-making and accountability in order to make integrated care work.\(^ {39}\) It will be important for providers to demonstrate an ability to engage with these critical success factors and demonstrate approaches to overcoming barriers to integration including:
  - overcoming cultural differences in management styles among professionals
  - information sharing
  - clear accountability for on-going care to facilitate effective hand-over and care co-ordination.\(^ {40}\)
- the Francis Report stresses the importance of robust leadership and a culture focused on patient safety as a sign of a high-performing organisation.\(^ {41}\) It makes the link between culture and compassionate care for older people across health and social care settings\(^ {42}\)
- the development of integration and co-ordination is essentially about promoting change and no change can be achieved without the support of all individuals involved.\(^ {43}\) Core elements of successful integrated care include creating time and space to develop an understanding of what is required, building trusting relationships and new ways of working. The Care Management of Services for Older people in Europe Network (CARMEN) framework\(^ {44}\) for integrated care for older people highlights the importance of providers developing a shared vision and policies which demonstrate key principles and values for the co-ordinated care of patients
- evidence suggests that good staff support and management are fundamental to a healthy organisational culture and are directly related to patient experience of care.\(^ {45}\) The National Voices group emphasise the term ‘person-centred’ to recognise that integrated care should both meet the needs of the service users across health and social care and their carers, but also that ‘services are likely to be better for their users if the people who deliver them are also cared for’
- a key aspect of effective patient-centred care is well-coordinated services, with joined-up working and effective communication between services and professionals. Across the literature, cultural differences in working styles are reported as a major barrier to integration. Therefore, key to achieving this vision will be encouraging colleagues in teams to work together at the front line to overcome organisational or logistical barriers, to create a common culture of working together, and focusing on the needs of the patient. Framing this is a benefit also to staff who are often motivated to deliver an effective, high quality service for the local population, and can be a significant factor in successful change\(^ {46}\)


\(^{46}\) Ibid
the degree of functional integration and experiences of staff have been monitored in a number of different pilots or programmes, using questionnaires for staff and non-participant observation methods. The clinical microsystem framework has been successfully used within the NHS to foster improvement work for the past three years. The clinical microsystem assessment tool, developed through systematic analyses of clinical microsystems in North America, is based on eight characteristics of success identified and translated into a self-assessment tool for organisations. This approach analyses ‘the 5Ps’ (Purpose, Patients, People, Processes, Patterns) to ensure that teams gather a comprehensive understanding of their functioning and can identify areas for improvement/development.

Sources:

- staff surveys (Employee Engagement, Satisfaction, Organisational Health)
- governance audit
- OD Improvement plan
- workforce development plan
- provider reporting of sickness rates, staff training, policies etc.
- 360 feedback and appraisal audit
- patient surveys.

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48 Available at: http://www.improvement.nhs.uk/heart/sustainability/further_resources/techniques/microsystems.html
## Overarching Domain C: Develop an organisational culture of joined-up working, patient centred care, empowered staff and effective information sharing

<table>
<thead>
<tr>
<th>Outcomes (overarching measures)</th>
<th>Indicators</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>C.1 Staff and whole organisations are committed to working in a joined up and integrated way and integrated working is evident across and within organisational boundaries</strong></td>
<td>C.1.1 Local partner organisations and their staff report effective joined-up working including GPs, social care, voluntary organisations, housing</td>
<td>Stakeholder 360</td>
</tr>
<tr>
<td></td>
<td>C.1.2 Local partner organisations and their staff report that there are adequate levels of community staff for various services e.g. to support end of life care in the community, district nursing, etc.</td>
<td>Stakeholder 360</td>
</tr>
<tr>
<td></td>
<td>C.1.3 Proportion of staff who report being able to redirect support for patients when they are unable to provide it themselves.</td>
<td>Staff survey</td>
</tr>
<tr>
<td><strong>C.2 There is evidence of progress towards transformational change of the workforce and work practices</strong></td>
<td>C.2.1 Change management plan &amp; evidence of progress</td>
<td>Transformational Dashboard (for development by provider)</td>
</tr>
<tr>
<td></td>
<td>C.2.2 Workforce review considering nursing skills mix and dependency review</td>
<td>CCG Quality Dashboard Metric 5</td>
</tr>
<tr>
<td></td>
<td>C.2.3 Staff engagement survey results and action plan for improvement</td>
<td>CCG Quality Dashboard Metric 13</td>
</tr>
<tr>
<td><strong>C.3 Effective information sharing and IT systems are in place and valued by staff across all local provider organisations</strong></td>
<td>C.3.1 A health and care summary and plan is accessible to all integrated care partners 24/7 (which includes contingency planning for emergencies or deterioration) for all patients over 65 identified as frail or those with a LTC</td>
<td>Stakeholder 360</td>
</tr>
<tr>
<td></td>
<td>C.3.2 Staff report that they collaborate with each other and can share information easily</td>
<td>Staff survey</td>
</tr>
<tr>
<td>Outcomes (overarching measures)</td>
<td>Indicators</td>
<td>Source</td>
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<tr>
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</tr>
<tr>
<td><strong>C.4 There is an organisational culture that supports staff to learn, improve and feel empowered</strong></td>
<td>C.4.1 Mandatory training needs analysis (TNA) to enable gaps in staff attitude, skills and knowledge to be identified, and develop shared training across organisations.</td>
<td>CCG Quality Dashboard Metric 14a</td>
</tr>
<tr>
<td>C.4.2 Number of eligible frontline staff who have completed training, and in:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Mandatory training as identified by TNA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• caring for individuals approaching the end of life and their carers/families</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• caring for individuals with mental health problems and their carers/families</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• caring for individuals with learning disabilities and reduced mental capacity and their carers/families</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• identifying at risk individuals and giving brief advice for healthier lifestyles, particularly in relation to a healthy diet, smoking, alcohol use, and physical activity.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C.4.3 Proportion of staff who report feeling supported to learn &amp; proportion of staff who report that they feel confident to use the skills described in C.4.2</td>
<td>Staff survey</td>
<td></td>
</tr>
<tr>
<td>C.4.4 Percentage of staff having up-to-date appraisals</td>
<td>CCG Quality Dashboard Metric 6a</td>
<td></td>
</tr>
<tr>
<td>C.4.5 Staff turnover &amp; vacancy rates &amp; rates of temporary staff employed</td>
<td>CCG Quality Dashboard Metric 6c, 6d, 6e</td>
<td></td>
</tr>
<tr>
<td>C.4.6 Staff absence &amp; sickness rates</td>
<td>CCG Quality Dashboard Metric 6b</td>
<td></td>
</tr>
</tbody>
</table>

**Additional quality dashboard reporting contract requirements for review by CCG, including:**

- Board / Board sub-committee level review and integrated action plan from the Francis reports, Compassion and Care Nursing, Delivering Dignity, Keogh and Berwick reports and other relevant national reports (CCG Quality Dashboard Metric 1);
- Equality & Diversity Annual Report (CCG Quality Dashboard Metric 24);
- Review of education reports (including Health Education EoE Quality Report, and evaluation from students / trainees) (CCG Quality Dashboard Metric 14c).
Pathway domain 1: Support older people and individuals with long
term conditions through early interventions and evidence-based care
to improve their health, wellbeing and maintain their independence

Rationale:

- this domain relates to NHS Outcomes Framework Domain 1: ‘Preventing people from dying prematurely’ and Domain 2: ‘Enhancing Quality of life for people with long-term conditions’; and the Public Health Outcomes Framework Domain 2: ‘People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities’

- this domain seeks to measure outcomes relating to community support for each of the three target populations:
  a. those who have a long term condition and are referred to community care services for support (outcomes 1.1, 1.2 & 1.3)
  b. those aged 65 and over who are pro-actively identified as ‘frail’ using risk stratification, and who receive early interventions to prevent deterioration their health and wellbeing and support them at home where possible (outcomes 1.4 & 1.5)
  c. mental health services (outcome 1.6) and preventative approaches to improve lifestyle and healthy behaviours upstream for the wider population of individuals over the age of 65.

For each of these groups, it is expected that providers will include a holistic physical and mental health assessment to prevent ill-health and promote wellbeing, including a preventative approach to encourage healthy lifestyles (outcomes 2.6 & 2.7).

- pro-active multidisciplinary, co-ordinated care for all patients identified as frail or with a known long term condition aims to support older people to manage their condition effectively at home, prevent future complications and reduce acute unexpected deteriorations requiring emergency admissions to hospital or residential care. The evidence suggests that the cumulative impact of multiple strategies for care integration is more likely to be successful in improving experiences patients, service users and carers. Case management and care coordination are less likely to succeed unless part of a ‘programme approach’ to a specific population group which includes good access to extended primary care services, supporting health promotion primary prevention, and coordinating community-based packages for rehabilitation and independent living.

- there are indicators throughout domains 1, 2 and 3 which measure the use of medicines reviews and reconciliation to ensure medicines prescribed for older people are optimised and the use of medicines produces the best possible outcome and value for the patient to maintain or increase their quality and duration of life. This is important to ensure that individuals do not suffer unnecessarily from illness caused by excessive, inappropriate, or inadequate consumption of medicines.

- key public health indicators also emphasise the relevance and importance of encouraging health behaviours to maintain a healthy weight and a balanced diet, preventing malnutrition, encouraging physical activity, smoking cessation, appropriate diabetic care and screening. Service specifications should incorporate evidence, best practice and address local need for these public health interventions to prevent ill health and promote wellbeing. In particular, evidence-based falls prevention strategies should be incorporated into services for older people including risk assessment and interventions to prevent falls or recurrent falls which may result in injury, particularly hip fractures.

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52 Ibid. See Chapter 5: ‘Falls Prevention’
• a vital aspect of ‘Supporting older people to maintain their independence, and reducing avoidable emergency admissions, re-admissions and extended stays in acute hospitals (including delayed transfers of care)’ involves a preventative and holistic approach to supporting older people in the community. The Cambridgeshire Joint Strategic Needs Assessment on the Prevention of Ill health in Older People focuses on multi-agency early interventions including falls prevention and active ageing, preventing social isolation and loneliness, supporting mental health and wellbeing, supporting carers and accessing local community support and information.

• partnership working is a vital part of supporting older people, recognising the importance of such wider determinants of health and wellbeing. Local health and community services will need to work closely with the Unitary Authority and County Council, District Councils, Community Safety Partnerships, Local Health Partnerships, Voluntary sector colleagues and the Older People Partnership Board plus local communities and interest groups.

• providers will be expected to adhere to all NICE quality standards and evidence-based practice and clinical pathways. The indicators below include some core clinical standards derived from either the Clinical Commissioning Group Outcomes framework (CCG OF) 2014-2015, NICE recommended indicators which were not chosen by DoH for inclusion in the national CCG OF or NICE quality standards which have been identified by LCG clinical leads in the local specifications. The CCG will be nationally monitored and local rates compared with other CCGs for those included in the CCG OF.

**Pathway domain 1: Support older people and people with long term conditions through early interventions and evidence-based care to improve their health, wellbeing and maintain their independence**

<table>
<thead>
<tr>
<th>Outcome: overarching measures</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Individuals with long term conditions experience improved control and reduced complications</td>
<td>1.1.1 Proportion of patients with diabetes (referred to community services) who demonstrate improvement in HbA1c.</td>
</tr>
<tr>
<td></td>
<td>1.1.2 Proportion of people with diabetes under the care of community services who experience a complication of diabetes.</td>
</tr>
<tr>
<td></td>
<td>1.1.3 Proportion of people with COPD who are referred to a pulmonary rehabilitation programme; and proportion who complete the programme.</td>
</tr>
</tbody>
</table>

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53 Ibid
56 NICE Menu of Indicators. Available at: http://www.nice.org.uk/aboutnice/qof/indicators.jsp.
<table>
<thead>
<tr>
<th>Outcome: overarching measures</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2 All individuals with a long term condition (under the care of community services), and their carers, feel supported to manage their condition and maintain their independence</td>
<td>1.2.1 Health related quality of life for those with a long term condition (initially for those under the care of community services, later a population measure).</td>
</tr>
<tr>
<td></td>
<td>1.2.2 Health related quality of life for carers of those with a long term condition (initially for those under the care of community services, later a population measure).</td>
</tr>
<tr>
<td></td>
<td>1.2.3 Proportion of patients with a LTC referred to community services who receive a community health care assessment within 14 days of a routine/non-urgent referral and commence appropriate care within 2 days of an assessment</td>
</tr>
<tr>
<td>1.3 The health and independence of frail older people is maintained or improved through proactive identification, assessment and care planning</td>
<td>1.3.1 Proportion of the population aged 65 and over who are pro-actively approached and assessed to identify those who are frail and have support needs.</td>
</tr>
<tr>
<td></td>
<td>1.3.2 Proportion of frail elderly patients:</td>
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<tr>
<td></td>
<td>- who receive an assessment within five days of date of a routine/non-urgent referral;</td>
</tr>
<tr>
<td></td>
<td>- whose care or intervention commence within two days of date of assessment.</td>
</tr>
<tr>
<td></td>
<td>1.3.3 Number of individuals identified as frail (either by MDT or in A&amp;E frailty scoring) who have a health and care summary and plan which is accessible to all integrated care partners 24/7 (which includes contingency planning for emergencies or deterioration) and a named lead professional for their care.</td>
</tr>
<tr>
<td></td>
<td>1.3.4 Proportion of referrals received by the lead provider from non-statutory organisations or individuals.</td>
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<tr>
<td></td>
<td>1.3.5 Proportion of individuals in contact with services who are signposted to voluntary sector services, District Council services (including housing support) and local community support for additional support or activities.</td>
</tr>
<tr>
<td>1.4 There is a reduction in the number of older people who suffer injury and/or fractures from a fall</td>
<td>1.4.1 Proportion of individuals aged 65 and over who have experienced a fall who experience another fall which results in injury within six months.</td>
</tr>
<tr>
<td></td>
<td>1.4.2 Incidence of hip and fragility fractures in individuals aged 65 and over.</td>
</tr>
<tr>
<td></td>
<td>1.4.3 Measurement of confidence and level of fear for an individual after a fall in people aged 65 and over.</td>
</tr>
<tr>
<td>1.5 Individuals experience improved mental health and wellbeing and quality of life through early support and diagnosis</td>
<td>1.5.1 Proportion of patients whose mental wellbeing improves following interventions (using validated scoring tools).</td>
</tr>
</tbody>
</table>
| Outcome: overarching measures | Indicator | 1.5.2 Proportion of patients with suspected mental health problems who are assessed and receive specialist care within specified time limits:  
| | | • crisis response within 4 hours  
| | | • urgent review within 24 hours  
| | | • routine review within 5 days.  

1.6 Evidence-based advice and interventions are made available to all people in contact with community services to promote healthy lifestyles and behaviours  

| 1.6.1 Number of contacts to raise healthy lifestyle issues and offer brief opportunistic advice by all trained staff and with other staff and/or patients. |
Pathway domain 2: Support older people (or those with a LTC) with an acute deterioration or inability to cope at home, to prevent avoidable admissions and reduce unnecessary hospital stays

Rationale:

- linked to NHS Outcomes Framework Domain 3: ‘Helping people to recover from episodes of ill health or following injury’

- the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)’s commissioning intention is to ‘improve out of hospital care for frail older people, and reduce ‘emergency bed days’ in terms of both admissions and the amount of time spent in hospital as a result of unplanned admissions.’\(^57\) This would deliver improved patient experience, better community care, and reduced unplanned admissions to hospital, where these can be safely avoided

- emergency admissions to hospital are often undesirable from the patient’s perspective, expensive for the health system and take resources away from elective admissions.\(^58\) Older people often do not wish to go into hospital if avoidable. If medically unnecessary, hospital admission also carries a risk of complications such as confusion and iatrogenic infection

- more than 70% of hospital bed days are occupied by emergency admissions. Whilst the majority of hospital admissions are for elective patients (55% in 2009/10) they occupy less than 30% of bed days. In Cambridgeshire in 2011/12, nearly 70% of all emergency occupied bed days were for people aged 65 or over

- emergency bed rates can be used as a proxy to assess the effectiveness of community support services for older people. A proportion of emergency admissions to hospital can be avoided if local systems are put in place to identify those at risk and target services, particularly primary care services. The aim is to reduce emergency hospital admissions for older people to only those due to medical necessity

- section 2.1 focuses on measuring emergency bed days, and admission rates for ambulatory care sensitive conditions’, conditions that should normally be managed in a primary or community care setting for which effective management and treatment should prevent admission to hospital. They can be classified as: chronic conditions, where effective care can prevent flare ups; acute conditions, where early intervention can prevent more serious progression; and preventable conditions, where immunisation and other interventions can prevent illness.\(^59\) Ambulatory care-sensitive conditions (ASCs) account for one in six emergency hospital admissions in England. Older people are predominantly admitted for chronic conditions and for vaccine-preventable conditions\(^60\)

- section 2.2. aims to ensure that there is no adverse impact on planned care services from this reduction in emergency care. These will be further developed during the next stage

- sections 2.3 & 2.4 relate to specific service standards and pathways for joined-up responsive services which can provide early interventions for frail older people to avoid them being unnecessarily admitted to hospital and reducing length of stay to that medically necessary. If effective, community services should be able to work together with partners to deliver more cost effective care at home. A rapid response by a multi-disciplinary team for some triaged patients may be able to organise appropriate health and social care support at home without need for admission to hospital or to minimise the length of stay required

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\(^{57}\) Cambridge and Peterborough Clinical Commissioning Group (CCG) Commissioning Intentions. Available at: www.cambridgeshire.nhs.uk

\(^{58}\) Potelakhoff E, Thompson J. ‘Emergency bed use: what the numbers tell us’. King’s Fund, December 2011.


• national recommendations for acute care of frail elderly (‘The Silver Book’)
  include a comprehensive geriatric assessment and early assessment by a specialist, and early supported discharge when medically fit

• section 2.5 indicators aim to measure the impact of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for adults aged 65 and over who were admitted as an emergency

• the National Voices Patient Survey report identified key patient statements which measure the extent of integrated, joined-up care during an acute admission or episode at home or in the community which can be used to triangulate patient experience of urgent care.

Sources:
• deonary uses service data on service use
• patient and carer surveys of experience
• dervice measures of waiting times and timely response
• service standards which illustrate the use of evidence-based care pathways, which are defined and collected by providers.

### Pathway domain 2: Support older people and those with a LTC with an acute deterioration or inability to cope at home, to prevent avoidable admissions and reduce unnecessary hospital stays

<table>
<thead>
<tr>
<th>Outcome: (overarching measures)</th>
<th>Indicator</th>
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</table>
| **2.1 Reduction in the number of days spent in hospital (from emergency admissions) by those aged 65 and over** | 2.1.1 Total emergency bed days for people aged 65 and over. (This will also include tracking of age group stratified data for those aged 65-74, 75-84, 85+) for:  
  • emergency bed days rate (per 100,000 population)  
  • average length of stay).  
  
  2.1.2 Assessment of whether patients in hospital are receiving the right level of care (eg clinical appropriateness protocol).  
  
  2.1.3 Rate of emergency hospital admissions for ambulatory care sensitive conditions in people aged 65 and over (eg angina, diabetes, heart failure, COPD, dementia).  
  
  2.1.4 Rate of emergency admissions for acute conditions that should not usually require hospital admissions in people aged 65 and over (eg urinary tract infections, heart failure). |
| **2.2 The impact of the programme on planned care is assessed and not adversely impacted** | 2.2.1 Indicators to be developed and discussed with provider as part of contract. |

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<table>
<thead>
<tr>
<th>Outcome: (overarching measures)</th>
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</table>
| **2.3 The community team effectively manages acute health episodes, minimising unnecessary hospital admissions where medically appropriate** | 2.3.1 Proportion of patients urgently referred to the community team who:  
- received an assessment (and home visit where required) within two hours of referral  
- received a care package to enable them to cope at home if medically appropriate, within 2 hours of assessment. |
| **2.4 When referred to hospital or presenting to A&E frail older people are pro-actively managed along an integrated frailty pathway** | 2.4.1 Proportion of patients aged 65 and over years who attend A&E who are screened for frailty within one hour of arrival. |
| | 2.4.2 Proportion of those assessed as frail who receive a comprehensive geriatric assessment by the frailty team within two hours of arrival and if admitted, are admitted under the care of a Care of the Elderly Consultant. |
| | 2.4.3 Proportion of patients aged 65 and over years who attend A&E and are known to the community MDT, whose health and care summary care plan is accessed within one hour of arrival and whose MDT is contacted for information or update within 48 hours of arrival. |
| | 2.4.4 Proportion of individuals aged 65 and over who are taking 4 or more medications, or have been admitted as an inpatient who receive a level 3 medication review (face to face) with a pharmacist or a doctor |
| **2.5 Patients aged 65 and over and those with LTCs experience a timely and supported discharge from acute or community settings** | 2.5.1 Delayed transfers of care from hospital for individuals aged 65 and over. |
| | 2.5.2 Proportion of people aged 65 and over who are offered reablement or rehabilitation following discharge from acute or community hospital; and proportion of those who accepted, who received it |
Pathway domain 3: Promote recovery, rehabilitation and sustainability of health and functional status after a period of ill health or injury, with supported discharge and reduced readmissions

**Rationale:**

- linked to NHS Outcomes Framework Domain 3: ‘Helping people to recover from episodes of ill health or following injury’

- interventions and effective integrated care to support those with long term conditions and/or those aged 65 and over who have experienced an acute episode managed at home or in acute or residential care should be effective and ensure a sustainable recovery

- health interventions and social care will play significant roles in putting in place the right re-ablement, rehabilitation and intermediate care services to support individuals to return home or regain their independence, so avoiding crisis in the short term. This should include rehabilitation or reablement support for those who require additional support to maintain or recover their previous level of function and wellbeing

- reablement seeks to support people and maximise their level of independence, in order to minimise their need to ongoing support and dependence on public services. There is strong evidence that reablement services lead to improved outcomes and value for money across the health and social care sectors

- in the absence of routine data on patient levels of function and well-being, a return to usual residence following discharge from hospital may act as a proxy for successful outcome of rehabilitation. Although the proportion of those who return to pre-admission category of accommodation will depend partly on the availability of support at home and the quality of community services, a change in the category of accommodation may suggest an important change in functional ability and health status

- healthcare, along with social care, is a major determinant of how well a patient recovers (including through rehabilitation) following illness or injury: if a person does not recover well, it is more likely that they will require hospital treatment again within the next 30 days. Thus, readmissions have been widely used as an indicator of the success of health and social care in helping people to recover. Emergency readmission to hospital is frequently used as proxy measure of avoidable adverse outcomes after initial or ‘index’ admission to hospital. This indicator, and its’ limitations, was reviewed by RAND prior to inclusion in NHS OF. Previous analyses have shown wide variation between similar NHS organisations in emergency readmission rates. Not all emergency readmissions are likely to be part of the originally planned treatment and some may be potentially avoidable.

**Sources:**

- secondary uses services (SUS) data on service use
- reporting measures from providers
- patient and carer surveys.

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63 http://www.bmj.com/content/suppl/2005/06/16/330.7505.1426.DC1/timely.pdf.

Pathway domain 3: Promote recovery, rehabilitation and sustainability of health and functional status after a period of ill health or injury, with supported discharge and reduced readmissions

<table>
<thead>
<tr>
<th>Outcomes (overarching measures)</th>
<th>Indicator</th>
</tr>
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<tbody>
<tr>
<td><strong>3.1 Patients make a sustainable recovery after admission to acute or intermediate care, with no avoidable deterioration in health</strong></td>
<td>3.1.1 Percentage of patients aged 65 and over transferred back to their original place of residence within seven days of admission.</td>
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<tr>
<td></td>
<td>3.1.2 Proportion of patients and carers who are assessed as having achieved the long-term health outcome or functional goals they desired/planned for jointly with staff (eg activities of daily living)</td>
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<td>3.1.3 Proportion of eligible patients who complete cardiac rehabilitation.</td>
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<td></td>
<td>3.1.4 Proportion of people aged 65 and over who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation services.</td>
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<td></td>
<td>3.1.5 Emergency readmissions within 30 days of discharge from hospital for those aged 65 and over.</td>
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<td></td>
<td>3.1.6 Number of individuals aged 65 and over who are admitted to residential/nursing care:</td>
</tr>
<tr>
<td></td>
<td>• incidence of new admissions to residential/nursing care</td>
</tr>
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<td></td>
<td>• prevalence of older people aged 65 and over in residential/nursing care settings.</td>
</tr>
<tr>
<td><strong>3.2 Patients feel supported in the community following discharge and during their recovery period</strong></td>
<td>3.2.1 Proportion of people 65 and over who are discharged from acute or community hospital with a health and care summary and plan, which considers their health and social care needs</td>
</tr>
<tr>
<td></td>
<td>3.2.2 Proportion of frail older people who are identified as requiring community follow-up who receive a community team contact (visit or phone call) after discharge from hospital or residential care. at a time agreed with in the plan</td>
</tr>
</tbody>
</table>
Pathway domain 4: Optimise the experience of care of people approaching the end of their lives (and their carers) in all settings and at all times of the day and night

Rationale:

- services that are needed by people who are dying span different settings and services. To deliver good care, services need to be well planned, responsive and above all compassionate. How a health system cares for those who are dying is an important indicator of the overall quality of care. This outcome domain aims to ensure fair accountability for the relevant sections of the end of life care system whilst providing data for improvement in care and, above all, the relevant care is delivered to patients.

- these outcomes link to NHS Outcomes Framework targets to improve the experience of care for people at the end of their lives and achieve NICE Quality Standards for End of Life care. It is expected that all providers will meet these NICE Quality standards.

- the proportion of deaths outside hospital has been used for some years as a national indicator for End of Life Care. There is evidence that, for those who state a preference, two thirds would prefer to die at home. However there is evidence that people change their preference of place of death as they age and in the last few days of their lives and that it becomes less important for them compared to other factors such as pain control. It is thought that between 8 and 25% of deaths are “unexpected” and so this might represent the minimum that might be expected to occur in a hospital environment.

- a National Voices survey has been developed that has been validated. This survey is national and is recognised to be a valid way of gathering the views of carers in lieu of patient experience of end of life care. There is scope to develop a similar ‘mini voices’ questionnaire as a proxy patient related outcome for end of life care in Cambridgeshire and Peterborough.

- ‘Making the case for change: electronic palliative care co-ordination systems’ (National End of Life Care Programme Oct 2012) outlines the potential benefits and cost savings of electronic record sharing in end of life care and gives some early case studies. For Cambridgeshire and Peterborough patients these are possible benefits are there is as yet no evidence of the benefits of such systems locally.

- an evaluation by the Nuffield Trust has shown that Marie-Curie sitting services reduces hospital admission for people who are dying.

- each indicator should include geographical data to assess potential inequalities in access and quality of care provided, as well as disease specific data as people dying from causes other than cancer tend to have a lower quality of end of life care. Regardless of the providers operating in each system and section of the service, data needs to be comparable across the whole of the CCG area.

Sources:

- service activity data from Commissioning Data Set (CDS)
- bespoke carer surveys to assess patient and carer experience
- reporting measures from providers from the electronic palliative care co-ordination systems’ to ensure NICE quality standards are met and evidence-based practice is employed
- feedback from GPs and community staff to assess whether adequate levels of staff and support are available and staff feel trained and confident to care for patients approaching the end of life.


Pathway domain 4: Optimise the experience of care of people approaching the end of their lives (and their carers) in all settings and at all times of the day and night

<table>
<thead>
<tr>
<th>Outcome (overarching measures)</th>
<th>Indicators</th>
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<tbody>
<tr>
<td><strong>4.1</strong> The quality of care experienced by the person who died, and their families, as reported by carers, was excellent - analysed by place of death to assess differences in home, hospice or acute setting.</td>
<td><strong>4.1.1</strong> Proportion of carers who state that overall, taking all services into account, the quality of care for the person who died could be rated as outstanding, excellent or good.</td>
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<tr>
<td><strong>4.1.2</strong> Proportion of carers who state that overall the level of support given in the following areas was excellent or good for:</td>
<td></td>
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<tr>
<td>• relief of pain</td>
<td></td>
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<tr>
<td>• relief of symptoms other than pain</td>
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<tr>
<td>• spiritual support</td>
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<td>• emotional support</td>
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<td>• support to state where they wanted.</td>
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<tr>
<td><strong>4.2</strong> Community staff are available who are trained and enabled to look after those who are dying in an appropriate and compassionate way</td>
<td><strong>4.2.1</strong> Proportion of patients who receive a night sitting services within 12 hours of request (and reduction in inequality of provision of this service across the CCG).</td>
</tr>
<tr>
<td><strong>4.2.2</strong> Proportion of people identified in either the acute setting or a hospice setting as dying and wanting to die at home who can be discharged within six hours with a suitable care plan and package.</td>
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<tr>
<td><strong>4.3</strong> Those who are dying can access high quality care which is co-ordinated across different agencies and staff.</td>
<td><strong>4.3.1</strong> Percentage of those who die aged 18 and over who are on an End of Life Care Register and whose record includes:</td>
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<tr>
<td>• whether a ‘do not attempt resuscitation’ note was discussed with them and documented</td>
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<tr>
<td>• whether they were either asked about their preferred place of death or who were not asked as the assessment of a clinician was that this was not the conversation that the dying person wished to have.</td>
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<tr>
<td>• stratified by area of residence to assess reduction in inequality;</td>
<td></td>
</tr>
<tr>
<td>• analysed by disease state (underlying diagnosis of cardiovascular and respiratory disease).</td>
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<tr>
<td><strong>4.3.2</strong> Percentage of those on the end of life care register who had ‘just in case’ medication available at the time of their death (or in a specified number of days prior to their death).</td>
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<tr>
<td><strong>4.3.3</strong> Percentage of those with a stated preferred place of death who died in that setting.</td>
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<tr>
<td><strong>4.3.4</strong> Proportion of all deaths in those aged 18 and over who die in an Acute Hospital setting; and a hospice setting:</td>
<td></td>
</tr>
<tr>
<td>• stratified by area of residence to assess reduction in inequality</td>
<td></td>
</tr>
<tr>
<td>• analysed by disease state (underlying diagnosis of cardiovascular and respiratory disease).</td>
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